Endorsed by American Association of Orthodontists®

Insurance

Orthodontist Professional Liability Insurance Application

AAO Endorsed Insurance Program • Administered by Lockton Affinity, LLC

If coverage is being requested for five (5) or more individuals, do not complete this application. Please complete the Group Professional Liability Application instead.

INSTRUCTIONS TO APPLICANT

1. All questions must be answered completely. Please type or print clearly.
2. This application and all supplemental forms must be signed and dated by the applicant.

Required Attachments to Bind Coverage

The following items are required before coverage can be bound. Please check each item included with your submission:

- ☐ Comprehensive informed consent document used in the practice
- ☐ Five (5) years of currently valued, carrier-generated loss runs (if available)
- ☐ Current professional liability policy declarations page

1 General Information

Applicant

First name | MI | Last name | Birth date

Home street address | City | County | State | ZIP

Email | Home phone | Cell phone

AAO member no. | Dental NPI number

Credentials and standing

1. **Are you currently serving, or have you served within the past 12 months, in any branch of the U.S. Armed Forces?** ○ Yes ○ No

If Yes, branch / status

2. **Education:**

Dental school | Year of graduation

Orthodontic program | Year of graduation

3. Have you obtained a recognized fellowship designation? ○ Yes ○ No

If Yes, designation

Ownership

4. Are you the owner of an orthodontic practice? ○ Yes ○ No

If Yes, select the business form

○ Incorporated ○ LLC ○ PA ○ Partnership

○ LLP ○ SC ○ Other

If Other, specify

If you answered Yes and are incorporated, you must have your legal entity named on your policy.

5. Business name(s) of your practice and/or other corporation, partnership, PA, LLC, SC, or other legal entity you own to be insured: ○ Not Applicable

Legal entity name(s)

6. Do you work for an organization (that you do NOT own) that provides professional liability insurance for you? ○ Yes ○ No

If Yes, list applicable locations

Any location covered by another insurer will be excluded.

7. Are you currently employed by, or affiliated with, a Corporate Group, Dental Support Organization (DSO), or Orthodontic Support Organization (OSO)? ○ Yes ○ No

If Yes, provide organization(s) name

8. Are you requesting additional insured coverage for an entity in which you have NO ownership interest? ○ Yes ○ No

If Yes, name & address of additional insured(s)

Coverage for additional insureds must be shared with the applicant's limits of liability.

Office locations

9. Primary office location:

Street address | Years at this location

City | County | State | ZIP | Phone

10. Secondary office location:

Street address | Years at this location

City | County | State | ZIP | Phone

11. Additional office locations:

List any additional office locations from the past 5 years, or back to your retroactive date if it is earlier.

Additional office location(s)

12. Preferred mailing address:

○ Same as home address ○ Same as primary office ○ Same as secondary office ○ Other

If Other, provide mailing address

2 Coverage Requested

Current coverage

13. Do you currently have professional liability insurance? *If No, skip to question 16.* ○ Yes ○ No

14. List previous insurance information:

Complete the current and previous professional liability carrier(s) for the past three (3) years.

Policy term	Name of carrier	Limit each claim / aggregate	Coverage form	Retroactive date
			○ Claims-made ○ Occurrence	
			○ Claims-made ○ Occurrence	
			○ Claims-made ○ Occurrence	

15. If you have a claims-made policy, have you purchased an extended reporting period endorsement from your prior carrier? ○ Yes ○ No ○ N/A

16. Have you ever practiced without insurance, or had a claims-made policy lapse without purchasing the extended reporting period ("tail") endorsement? ○ Yes ○ No

If Yes, provide details and note dates

Coverage requested

17. Total number of orthodontists to be insured on this policy:

18. Select the coverage form requested:

○ Occurrence ○ Claims-Made

19. If you are licensed in Indiana, Louisiana, or South Carolina: Are you currently enrolled in your state-sponsored Patient Compensation Fund (PCF), Health Care Stabilization Fund, Excess Liability Fund, or similar program?

○ Yes ○ No / Not Sure ○ N/A

If No / Not Sure, select your preference

○ Yes, I would like assistance determining whether participation is available or required in my state

○ No, I would not like assistance

20. Total Limits of Liability requested: *(each claim / aggregate)*

- ○ $1,000,000 / $3,000,000
- ○ $2,000,000 / $4,000,000
- ○ $2,000,000 / $6,000,000
- ○ My underlying limit is set by my state's Patient Compensation Fund (PCF)

State	If your fund is	Required underlying limit
Indiana	Indiana Patient's Compensation Fund (PCF)	$500,000 / $1,500,000
Louisiana	Louisiana Patient's Compensation Fund (PCF)	$100,000 / $300,000
South Carolina	South Carolina Patients' Compensation Fund (now part of SCMMA)	$200,000 / $600,000

21. Policy limit structure requested:

- ○ **Shared Limits Available to All Insureds**
  A single limit of liability is shared by all insureds on the policy.
- ○ **Separate Limits Available to Each Scheduled Professional – Shared with all Other Insureds**
  A separate limit applies to each orthodontist, shared with their organization and with their employees.
- ○ **Separate Limits Available to Each Scheduled Professional – Not Shared with Other Insureds**
  A separate limit applies to each orthodontist and is shared with their organization, but not with employees. Employees share a single separate limit.

3 Applicant & Practice Information

Licensure

22. State dental licensure:

List every U.S. state in which you hold or have held an active dental license. For each, provide the license number, the date licensed, and its expiration date.

State	License #	Date licensed	Expiration date

Academic appointment

23. Do you teach or supervise students in any graduate orthodontic program? *If No, skip to question 26.* ○ Yes ○ No

If Yes, school / program name

24. Select your graduate orthodontic program faculty status:

- ○ Full-time faculty
- ○ Part-time faculty

25. Does this school / program provide professional liability insurance for your clinical supervision of students? ○ Yes ○ No

Practice profile

26. Practice personnel — number of individuals you employ, contract, or supervise in each role:

Role	Number	Role	Number
Orthodontist		Front Office / Administrative Staff	
Orthodontic / Dental Assistant		Lab Technician	
Dental Hygienist		Other	

If Other, list role(s)

27. How many total hours per week do you practice?

28. What is your average weekly patient volume?

4 Practice Operations

Scope of practice

29. Do you perform any of the following? ○ Yes ○ No

- *Non-autologous stem cell therapy*
- *Diagnosis or treatment of active periodontal disease*
- *Periodontal, implant, or regenerative surgery*
- *Oral and maxillofacial surgery, including any extractions other than minor appliance-related procedures*
- *Endodontic procedures*
- *Diagnosis or treatment of TMJ / TMD beyond orthodontic occlusal management*
- *Administration of general anesthesia, IV sedation, or deep sedation*
- *Medical / dental services unrelated to orthodontic tooth movement or occlusal correction*
- *Appliances marketed for adult jaw growth, skeletal remodeling, facial alteration, or airway cure (AGGA / ARA / ORA)*
- *Manufacturing, selling, or distributing dental products, appliances, or devices beyond dispensing to your own patients*
- *Prescription weight-control service*
- *Restorative dentistry or prosthodontic treatment*

If Yes, provide details

30. Have you ever added or discontinued procedures that are considered outside of, or not usual to, the dental specialty of orthodontics, or that are experimental in nature? ○ Yes ○ No

If Yes, list the procedures/services and note the dates of change(s)

31. Do you perform cosmetic injectable procedures (Botox / fillers)? ○ Yes ○ No

If Yes, complete the Botox / Dermal Filler Supplemental Application for coverage.

32. Do your extraoral force systems employ patient safety mechanisms? ○ Yes ○ No ○ N/A

If No, explain

Prescribing and practice settings

33. What percentage of your practice involves opioid prescriptions? ____ %

34. Do you treat patients located inside a correctional facility? ○ Yes ○ No

35. Are you contractually (or otherwise) the prescribing orthodontist for a telehealth practice / service NOT directly associated with your practice? ○ Yes ○ No

If Yes, provide details

36. Do you serve as medical director or provide medical oversight for any entity NOT owned by you or another Named Insured orthodontist? ○ Yes ○ No

If Yes, provide details

Background disclosures

37. Answer the following about yourself:

a. Treated for alcoholism, narcotics addiction, mental illness, or physical impairment? ○ Yes ○ No

b. Subject of any current, pending, or prior investigation by a local / state / national dental organization or governmental agency (including your state dental board or the DEA)? ○ Yes ○ No

c. Subject of any disciplinary action by a local / state / national association? ○ Yes ○ No

d. State dental license or federal narcotics (DEA) registration denied, revoked, suspended, restricted, placed on probation, subjected to any disciplinary or corrective action, or voluntarily surrendered? ○ Yes ○ No

e. Membership in any professional association refused, suspended, or revoked? ○ Yes ○ No

f. Charged or convicted of any criminal act, including DUI (other than minor traffic)? ○ Yes ○ No

g. Aware of any incident, fact, circumstance, act, error, or omission that may result in a professional liability claim that has not been reported to your current carrier or a prior carrier? ○ Yes ○ No

h. Has professional liability insurance ever been refused, cancelled, or non-renewed? ○ Yes ○ No

i. Have you knowingly made or caused any false statement or material misrepresentation in applying for insurance? ○ Yes ○ No

If Yes, provide details and attach all documentation

Risk management

38. Do you consistently utilize written informed consent forms and procedure-specific supplemental consent forms with your patients when appropriate? ○ Yes ○ No

39. Are signed informed consent forms retained in the patient's permanent medical record? ○ Yes ○ No

40. Have you completed at least one accredited risk-management / CE course in the past 12 months? ○ Yes ○ No

Provider	Course name	Date completed

5 Acknowledgements

The Applicant represents that the information submitted in this application and attachments is true, complete, and current, and that the Applicant consistently utilizes a Comprehensive Informed Consent document. The execution and submission of this Application shall not bind the Company or its administrator to issue insurance, nor shall it bind the Applicant to acceptance of a policy. However, if a policy is issued and accepted, all representations in this Application shall be binding. The Company reserves the right to amend the terms, conditions, and limitations of any policy issued. The Applicant agrees to immediately provide written notice of any change in the information supplied, and authorizes all former liability insurers to furnish the Company with all available information concerning the Applicant. The statements in this Application are fully incorporated into the policy if issued.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. The state-specific fraud notices attached to this application apply.

Individual applicant — signature

Date

Coverage underwritten by Arch Specialty Insurance Company

Arch | Insurance

State-Specific Fraud Notices

The following notices are required by state law and form part of this application. The notice for the state in which you reside, or in which this application is signed, applies to you.

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who, knowingly and with intent to defraud or facilitate a fraud against any insurance company or other person, submits an application with deceptive and materially false information in order to gain acceptance of the risk by the Insurer, or files a claim for insurance containing any false, deceptive, or misleading material information may be guilty of insurance fraud.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO UTAH APPLICANTS: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.